EDMUND G. BROWN JR.
Attorney General of California
FRANK H. PACOE
Supervising Deputy Attorney General
HANNAH ROSE, Deputy Attorney General
State Bar No. 56276
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5515
Facsimile: (415) 703-5480
Attorneys for Complainant

LYDIA ZANE
Senior Legal Analyst

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CHARLES WILLIAM STAUBITZ** **1012 Swan River Court** **Vacaville, CA 95687** **Registered Nurse License No. 644021** Respondent.	Case No. 2010-496 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 2004, the Board of Registered Nursing issued Registered Nurse License Number RN 644021 to Charles William Staubitz (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on February 29, 2012, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section

references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . .

7. Section 2762 of the Code states:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

. . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and

enforcement of the case.

REGULATORY PROVISIONS

9. California Code of Regulations, Title 16, ("CCR"), section 1442 sets forth the definition of "gross negligence" as follows:

As used in section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

10. CCR section 1443 provides that, as used in section 2761 of the Code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in section 1443.5.

11. CCR section 1443.5, states in pertinent part, that a registered nurse shall be considered to be competent when he or she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process.

DRUGS

Hydromorphone Hydrochloride, also known by the brand name **Dilaudid**, is a semi-synthetic opioid derivative subject to control as a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K), and a dangerous drug within the meaning of Code section 4022. Hydromorphone hydrochoride is a strong analgesic used in the relief of moderate to severe pain.

Lorazepam is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug within the meaning of Code section 4022. Lorazepam, also known by the brand name **Ativan**, is a benzodiazepine, used for the management of anxiety disorders, seizure conditions and for purposes of pre-operative sedation

and anxiety relief.

Morphine Sulfate is a phenanthrene-derivative agonist and the principal alkaloid of opium. It is a powerful analgesic used to relieve severe, acute pain or moderate to severe chronic pain. It is also used for pre-operative sedation or as a supplement to anesthesia. As a single entity, morphine sulfate is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug within the meaning of Code section 4022.

Fentanyl and Fentanyl Citrate are Schedule II controlled substances as designated by Health and Safety Code section 11055, subdivision (c)(8), and dangerous drugs within the meaning of Code section 4022. Fentanyl and Fentanyl Citrate are strong analgesics, pharmacodynamically similar to meperidine and morphine. They are used pre-operatively, during surgery and in the immediate post-operative period, as well as for the management of breakthrough cancer pain.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Incompetence and/or Gross Negligence)

12. Respondent is subject to disciplinary action under Code section 2761(a)(1), unprofessional conduct, gross negligence, as defined in CCR section 1442, and/or incompetence, as defined in CCR sections 1443 and 1443.5, in that while employed as a Registered Nurse at VacaValley Hospital, Respondent repeatedly made false and/or grossly incorrect, grossly inconsistent, entries in the hospital's medication dispensing records (Pyxis) resulting in numerous drug discrepancies for patients as follows:

a. **Patient B**: 1 mg of Hydromorphone unaccounted for.

The Pyxis Record indicated that on November 25, 2007, Respondent withdrew 1 mg tab of Hydromorphone (Dilaudid) for Patient B. There is no documentation to show that Hydromorphone was prescribed for this patient and no further documentation to show that Respondent administered the medication to the patient or otherwise accounted for its wastage.

b. **Patient E**: No mention of subject in documentation. Hydrocodone two 5-500 mg and one 6 pack unaccounted for.

On November 2, 2007, at 22:35 hours, according to Pyxis, Respondent withdrew two 5-500 mg tabs of Hydrocodone and 1 tab of Hydromorphone/APAP (6 pack) for this patient. There is no documentation to show that Hydrocodone was prescribed for the patient. There was no further documentation to show that Respondent administered either the Hydrocodone and/or the Hydromorphone/APAP to the patient and no further documentation to show that Respondent administered the medication to the patient or accounted for its wastage.

c. **Patient F**: One 6 pack of Hydrocodone unaccounted for.

According to Pyxis, Respondent withdrew a 6 pack of Hydrocodone/APAP on November 2, 2007, at 19:32 hours. There is no documentation to show that Hydromorphone/APAP was prescribed for this patient and no further documentation to show that Respondent administered the medication to the patient or accounted for its wastage.

d. **Patient H**: Ativan 1.5 mg unaccounted for.

According to Pyxis, Respondent withdrew Lorazepam (Ativan) 2 mg/ml inj. on September 21, 2007 at 17:15 hours. There was no documentation to show that Ativan was ordered for this patient. The patient's medical administration record indicated that the patient was given Ativan 0.5 mg at 17:30 hours. There was no further documentation to account for the wastage of the remaining amount.

e. **Patient I**: Dilaudid 1 mg unaccounted for.

According to Pyxis, on September 16, 2007, at 23:27 hours, Respondent removed 2 mg of Dilaudid. The patient's orders were for Hydromorphone (Dilaudid) 2 mg im (at 23:30 hours). May repeat in 20 minutes as needed, September 16, 2007. The patient's medication administration record indicated that 2 mg of Dilaudid was given at 23:50 hours. Respondent then removed 2 mg/1 ml inj. of Dilaudid at 00:16 hours on September 17, 2007. The patient's flow sheet record indicated that the patient was given 1 mg of Dilaudid at 11:50 hours. There was no further documentation to show an accounting of the remaining 1mg of Dilaudid.

f. **Patient K**: Morphine Sulfate 4 mg unaccounted for.

Patient K had orders for Morphine Sulfate, 6 mg, IVP. According to Pyxis, on August 14, 2007, at 23:22 hours, Respondent removed 10 mg of Morphine Sulfate for Patient K. The

patient's record indicated that 6 mg of Morphine was given to the patient at 23:26 hours. No waste noted for the remaining 4 mg of Morphine.

g. **Patient L**: Dilaudid 0.5 mg unaccounted for.

Patient L's orders were for Dilaudid 0.5 mg IV at 19:30 hours on August 14, 2007. According to Pyxis, Respondent removed 1 mg/ml inj. of Hydromorphone on August 14, 2007, at 19:31 hours. Dilaudid .5mg IV at 19:30 hours is noted in the patient's medication administration record. There is no further documentation to show that Respondent administered the remaining 0.5 mg of Dilaudid to the patient or that the remaining amount was wasted.

h. **Patient M**: Dilaudid 0.5 mg unaccounted for.

Patient M's orders were for Dilaudid 0.5mg IV at 00:30 hours on August 10, 2007. According to Pyxis, Respondent removed 1 mg/ml of Hydromorphine inj. at 00:27 hours on August 11, 2007. The patient's record indicated that Dilaudid 0.5mg was administered at 00:30 hours. The patient's flow chart for August 11, 2007, shows that .5mg of Dilaudid was given to the patient at 00:32 hours. There is no further documentation to show that Respondent administered the remaining 0.5 mg of Dilaudid to the patient or that the remaining amount was wasted.

i. **Patient N**: Morphine Sulfate 4 mg unaccounted for.

Patient N's orders were for Morphine 6 mg IV now at 22:00 hours on July 25, 2007. According to Pyxis, Respondent removed 10 mg/1ml of Morphine at 22:41 hours on July 25, 2007. The patient's medication administration record indicates that Respondent administered 6 mg of Morphine at 22:00 hours and 22:45 hours. The flow chart notation for July 25, 2007, indicates only the time 10:00 hours. There is no further documentation to show that Respondent administered the remaining 4 mg of Morphine to the patient or that the remaining amount was wasted.

j. **Patient O**: Hydrocodone/APAP 6 pack unaccounted for.

According to Pyxis, Respondent removed Hydrocodone/APAP 6 pack for Patient O at 21:00 hours on July 17, 2007. There is no documentation to show that Hydrocodone/APAP was prescribed for this patient and no further documentation to show that Respondent administered

the medication to the patient or otherwise accounted for its wastage.

k. **Patient P**: Morphine 2-4 mg/ml Tubex unaccounted for.

The patient's orders were for Morphine 2 mg IM, dated July 11, 2007. According to Pyxis, Respondent removed 4 mg/ml of Morphine Tubex on July 11, 2007, at 18:42 hours. The medication administration record indicates that 2 mg of Morphine was administered at 18:47 hours on July 11, 2007. There is no further documentation to indicate if the remaining 2 mg of Morphine was given to the patient or if the excess amount was wasted.

l. **Patient Q**: Morphine 2 mg/ml Tube unaccounted for.

The patient's orders were or Morphine 2 mg IV every 10 minutes as needed for pain, dated July 13, 2007. According to Pyxis, on July 13, 2007, Respondent removed Morphine 4 mg/1 ml Tube at 17:26 hours and again at 20:16 hours for a total of 8 mg of Morphine removed. The patient's medication administration record indicated that 2 mg of Morphine was administered at 17:45 hours, 17:55 hours and at 20:15 hours. The patient's flow chart indicated that 2 mg of Morphine was given at 17:44 hours and at 18:01 hours. There is no further documentation to show that Respondent administered the remaining 2 mg of Morphine to the patient or to otherwise account for its wastage.

m. **Patient R**: 50 mcg-150 mcg Fentanyl unaccounted for.

This patient had Physician's orders for Fentanyl 100 mcg IV two times on July 12, 2007. According to Pyxis, on July 12, 2007, at 11:55 hours, Respondent removed 250 mcg/5 ml amp of Fentanyl Citrate. The patient's medication administration records and flow chart indicated that 100 mcg of Fentanyl was given to the patient at 23:04 hours on July 12, 2007. There is no further documentation to show if Respondent administered the remaining 50 mcg-150 mcg of Fentanyl to the patient or if the excess amount of Fentanyl was wasted.

n. **Patient T**: 1 mg Dilaudid and one Hydrocodone/APAP unaccounted for.

Patient T's orders state Dilaudid 2 mg IV, Dilaudid 3 mg IV, dated June 5, 2007. According to Pyxis, on June 4, 2007, Respondent removed 1 Hydromorphone inj, 2 mg/1 ml, at 23:02 hours. The patient's medication administration records indicated that the medication was given on June 4, 2007, at 23:23 hours and again at 00:17 hours. The patient's flow chart

indicated that Dilaudid 2 mg IV was given to the patient on June 4, 2007, at 11:23 hours.

On June 5, 2007, Respondent removed 2 Hydromorphone inj. 2 mg/1 ml at 00:09 hours and one Hydrocodone 6 pack at 00:41 hours according to Pyxis. The patient's flow chart indicated that the patient was given 3 mg Dilaudid IV at 00:17 hours on June 5, 2007. There is no further documentation to account for 1 mg of Dilaudid remaining and 1 Hydrocodone/APAP 6 pack that Respondent withdrew for Patient T. Further, the Pyxis record indicated that Respondent removed Dilaudid and Hydrocodone/APAP for Patient T one day before the Physician's orders for the medication was noted in the patient's record.

SECOND CAUSE FOR DISCIPLINE

13. Respondent is subject to disciplinary action under Code section 2762(e), in that, while employed as a Registered Nurse at Vaca Valley Hospital, Respondent made false and/or grossly incorrect, grossly inconsistent, entries in the hospital's medication dispensing records (Pyxis) resulting in numerous drug discrepancies for patients as set forth in paragraph 12, subsections 12a through 12n, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number RN644021, issued to Charles William Staubitz.

2. Ordering Charles William Staubitz to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 4/13/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SF2009405719/20257478.doc